City of Long Beach
DEPARTMENT OF HUMAN RESOURCES

RETURN TO WORK FROM MEDICAL DISABILITY

TO BE COMPLETED BY PHYSICIAN

I hereby certify that _____ was under my professional care
(Employee's Name)

from _____ to _____ , and that I consider the patient recovered and able
(Date) **(Date)**

to return to perform his/her regular duties effective _____.
(Date)

(PLEASE PRINT OR TYPE)

_____
Physician's Signature

_____
Physician's Name

_____
Date

_____
Title

_____
Address

_____
City/State **Zip Code**

_____
Telephone Number

Original: **Department of Health and Human Services**
Copies: **Department File**
Physician File

Created 04/2004